Banner Health

Title: Compliance: 60 Day Report/Repay Overpayments		
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Approved by: Administrative Policy Committee, Chief Legal Officer/General Counsel, PolicyTech Administrators		

Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Behavioral Health Hospital
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Ocotillo Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner--University Medical Center Phoenix
Banner--University Medical Center South
Banner--University Medical Center Tucson
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Banner Corporate

Ambulatory (Outpatient) Services
Banner Health Clinics
Banner Imaging Services
Banner Imaging Services Colorado
Banner MD Anderson Cancer Center
Banner Sleep Center
Banner Surgery Centers
Banner Urgent Care Services
Occupational Health/Employee Health Services
Rural Health Clinics

Banner Home Care and Hospice (BHCH)

Banner Pharmacy Services

Post Acute Services (PAC)

Research

I. Purpose/Population:

A. **Purpose**:
   1. To ensure that Banner reports and returns Overpayments to Federal Health Care Programs within sixty (60) days of the identification and quantification, as required by law. Failure to comply with the requirements of this policy can lead to liability under the False Claims Act.

B. **Population**: All Employees

II. Definitions:

A. Corporate Integrity Agreement (CIA): A five-year agreement that Banner entered into on April 9, 2018 with the U.S. Department of Health and Human Services Office of Inspector General (OIG) as part of a settlement with the Department of Justice.

B. Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded in whole or in part by the United States Government (other than the Federal Employees Health Benefit Program) or any State health care program (as defined in 42 U.S.C. § 1320a-7(h)). Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Indian Health Service, TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.

C. Identified: When Banner Health has determined or should have determined through the exercise of Reasonable Diligence, that (1) an Overpayment has been received and (2) the amount of the Overpayment has been quantified.

D. Lookback Period: Six (6) years from the date that an Overpayment is received.

E. Overpayment: Any funds that Banner has received in excess of the amount due and payable under Federal Health Care Program requirements.

F. Reasonable Diligence: Consists of both:
   1. Proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of Overpayments; and
   2. Investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of potential Overpayments.

G. Substantial Overpayment: For purposes of this policy, a Substantial Overpayment is defined as a single Overpayment or a series of Overpayments that (1) meet(s) a threshold amount of $100,000 and (2) are considered substantial based on several factors, including, but not limited to, the number of affected claims, the time period over which the Overpayment(s) occurred, the dollar amount involved, and the nature of the error that led to the Overpayment(s).

III. Policy:

A. Banner is committed to complying with all applicable Federal Health Care Program requirements for billing and claims reimbursement, including the preparation and submission of accurate claims consistent with such requirements.

B. Banner exercises Reasonable Diligence to Identify Overpayments from Federal Health Care Programs.
   1. Banner conducts proactive compliance activities to monitor the accuracy and appropriateness of claims submitted to Federal Health Care Programs. Publicly available information, such as OIG work plans and the Centers for Medicare and Medicaid Services (CMS) guidance, may be considered when planning such monitoring activities.
   2. Banner investigates information that supports a reasonable belief that an Overpayment has been received based on the facts and circumstances of the situation. For example, audit findings by CMS, the OIG, or government contractors may be credible information of a potential Overpayment.
      a. Investigations are generally completed within six (6) months from the receipt of credible information of potential Overpayments, except in extraordinary circumstances.
   3. Overpayments may be the result of non-adherence to Federal Health Care Program requirement, errors by Banner personnel, payment processing errors by Federal Health Care Programs, or erroneous or incomplete information provided by the patient or his/her responsible party.
   4. If a single overpaid claim is found, Banner may inquire further to determine whether there are more claims with the same issue before reporting and returning the Overpayment.
   5. Any single Overpayment or series of Overpayments greater than or equal to $100,000 must be immediately reported to the Ethics & Compliance Department in accordance with the Compliance: Reporting and Investigating Potential Compliance Issues policy.
      a. If the investigation reveals that the Overpayment may be substantial, the issue is referred to the Reportable Events Committee (REC). The REC will consider several factors in making the determination whether the Overpayment is a Substantial Overpayment.
      b. If the REC determines that a Substantial Overpayment has occurred, the Ethics & Compliance Department will notify the OIG within thirty (30) days of the REC making that determination.

C. Overpayments must be reported and returned to the applicable Federal Health Care Program using a claims adjustment, credit balance, self-reported refund, or other reporting process no later than sixty (60) days after the Overpayments are Identified.
   1. Overpayments that are routinely reconciled or adjusted pursuant to Federal Health Care Program policies and procedures are handled in accordance with such policies and procedures.
   2. The Ethics & Compliance Department decides whether to report and return an Overpayment using a method other than routine claims adjustment, including, but not limited to, using the OIG Self-Disclosure Protocol (SDP) or the CMS Voluntary Self-Referral Disclosure Protocol (SRDP).
      a. If Banner engages in either the SDP or SRDP, the 60-day reporting period is tolled and remains suspended until such time as a settlement is entered or Banner withdraws or is removed from protocol. If no settlement is reached with the government, Banner has the remaining balance of the 60-day period to report and return any Overpayments.
   3. Banner may use statistical sampling and extrapolation to approximate the amount of an Overpayment.
      a. If extrapolation can be completed within sixty (60) days, Banner does not need to separately report and return Overpayments on the claims in a probe sample.

4. If a Federal Health Care Program notifies Banner that it has committed a payment error and will adjust claims to correct the error, Banner does not need to separately report and return the Overpayment.

D. Banner reports and returns Overpayments that are Identified within the Lookback Period.

E. **Cost Reports**: Overpayments associated with cost reports may be reported by the Finance Department through the existing cost report reconciliation process on the date the corresponding cost report is due. The Finance Department may also need to revise past cost reports based on audit findings pertaining to the current cost report. For example, if a government contractor finds an improper cost report payment, the Finance Department may need to ascertain whether that finding constitutes credible information necessitating the review of other cost reports within the Lookback Period.

IV. Procedure/Interventions:

A. Identify Overpayments through the exercise of Reasonable Diligence and in the course of ordinary operations. (**All Employees**)

B. **Reporting and Returning Overpayments**:
1. No later than sixty (60) days after an Overpayment has been Identified, report the Overpayment using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the Federal Health Care Program.
   a. If applicable, refund Overpayments in accordance with the applicable Federal Health Care Program's policies and procedures. (**Revenue Cycle Department**)
      i. The Revenue Cycle Department will coordinate with the Ethics & Compliance Department, as necessary, to report and return the Overpayment.
   b. When indicated, determine whether to use an alternative reporting process, including, but not limited to, the SDP or SRDP, to report and return Overpayments. (**Ethics & Compliance Department**)
      i. When engaged in either the SDP or SRDP, the Ethics & Compliance Department coordinates the disclosure and uses the reporting process described in the applicable protocol. The Ethics & Compliance Department notifies the Finance Department of any disclosure using either the SDP or SRDP.
      ii. When using another reporting process, the Ethics & Compliance Department works with the Revenue Cycle Department, as necessary, to report and return Overpayments.
      iii. If the Overpayment is calculated using a sampling methodology for the SDP, SRDP, or other reporting process, the methodology is conducted in a manner that conforms to sound and accepted principles and is described in the report to the applicable Federal Health Care Program.
   c. If applicable, provide monitoring and oversight of the return of any Overpayments resulting from compliance audits and investigations. (**Ethics & Compliance Department**)

C. **Reporting and Returning Substantial Overpayments**
1. Immediately notify the Ethics & Compliance Department of any Overpayment or series of Overpayments that is greater than or equal to $100,000. (**All Employees**)
2. Leads and/or assists in the investigation of the potential Substantial Overpayments in accordance with Compliance: Reporting and Investigating Potential Compliance Issues policy. (**Ethics & Compliance Department**)
   a. The investigation will include a consideration of the factors to determine whether the Overpayments or series of Overpayment is substantial.

b. If the Overpayment appears to be substantial, the investigator completes the applicable form and attaches any supplemental information that will allow the REC to determine whether a Substantial Overpayment has occurred.
   i. If the REC decides that a Substantial Overpayment has occurred, the Ethics & Compliance Department will provide appropriate notification to the OIG within 30 days of that decision and will continue to make monthly updates to the OIG until the issue has been resolved.
   ii. A Substantial Overpayment will be reported and returned to the applicable Federal Health Care Program no later than 60 days after identification and quantification.
   iii. The Ethics & Compliance Department will inform the Finance Department, if necessary, of the Substantial Overpayment.
   iv. If the Overpayment does not appear to be substantial, the Ethics & Compliance Department works with the Revenue Cycle Department, as necessary, to report and return the Overpayment(s) within 60 days.

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. CMS Voluntary Self-Referral Disclosure Protocol, *available at* https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/self_referral_disclosure_protocol.html.
B. OIG Self-Disclosure Protocol, *available at* https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf.

VII. References:

A. Medicare Program; Reporting and Returning Overpayments, 81 Fed. Reg. 7654 (Feb. 12, 2016) (codified at 42 C.F.R. pts. 401 & 405).

VIII. Other Related Policies/Procedures:

A. Compliance: Reporting and Investigating Potential Compliance Issues

IX. Keywords and Keyword Phrases:

A. Overpayment
B. Substantial Overpayment
C. Federal Health Care Programs
D. 60 Days
E. Lookback Period

X. Appendix:

A. N/A